APA INSURANCE
GENERAL • LIFE • HEALTH

OUTPATIENT CLAIM FORM

PLEASE FILL OUT THIS FORM CLEARLY AND COMPLETELY IN BLOCK LETTERS

Please read every section carefully and fill out the form appropriately.

1. All fields MUST be completed to avoid delay or rejection of the authorisation.
2. A duly completed and signed outpatient form should be sent to care.team@apainsurance.org
3. For more information, please contact us through 0709 912 888 / 0722 200 100 / 0713 200 100 / 0720 600 577 / 0734 600 577.

Name of Hospital _____ Tel & Fax No_____

Name of Medical Scheme Provider: _____ Tel & Fax No_____

Name of Company/Client _____

Policy/Membership No _____

Employee's Name _____

Staff No. (If available) _____ Gender: Male ☐ Female ☐

Patient's Name _____ Date of Birth: D D M M Y Y Y Y

Relation to Insured: Self ☐ Spouse ☐ Child ☐

Hospital Registration No: _____ ID No. _____

Provisional/Final Diagnosis: _____ Date: D D M M Y Y Y Y

When was the condition first diagnosed:_____

When was the condition last treated:_____

Causes of illness(es): _____

_____

_____ (Or any known underlying condition)

Is the condition Congenital, Chronic or Recurring? _____

_____

_____

BILLS WILL BE PAYABLE AS PER AGREED TARIFF

Particulars	Cost	Bill No/Receipt Number
Consultation/Hospital Care		
Laboratory Investigations		
X-Ray/Diagnostic Services		
Dental		
Lenses		
Frames		
Medicine/Drugs/Injections		
Others - Please State		
Total		

OPTICAL

Date of Last Replacement: D D M M Y Y Y Y Current: D D M M Y Y Y Y

Eye	Sphere	Cylinder	Axis	Addition		Eye	Sphere	Cylinder	Axis	Addition
RE						RE				
LE						LE				

Spectacles are prescribe for (tick one): Correction of Sight ( )
Light Sensitivity ( )

Reason for New Spectacles (tick as many as apply): (tick as many as apply):

First time vision correction prescription	( )	Consultation Fees: Kshs.	_____
Change of frame due to wear and tear	( )	Frames: Kshs.	_____
Broken lenses beyond repair	( )	Lens: Kshs.	_____
Lenses broken or scratched	( )	Others: Kshs.	_____
Spectacles lost	( )	Total: Kshs.	_____
Patient Request	( )	APA Authorisation: Kshs.	_____
Other			

FOR DENTAL

Item	Specify	Cost
Consultation		
Procedure		
Extractions		
Fillings		
Root Canal		
Scaling		
Radiology		
Medication		

DOCTOR'S DECLARATION

I hereby confirm that the information provided above is correct and true to the best of my knowledge.

Doctor's Name: _____

Doctor's Signature & Stamp: _____

Date: D D M M Y Y Y Y

PATIENT'S DECLARATION

Authorisation to obtain and use information

Personal data refers to all information that may directly or indirectly identify you. In order to provide you with products and services, we need to collect, use, share and store your personal data. This may include information provided by you or obtained from third parties. The information may be used to assist us in providing the service you are applying for and shall be used in fulfillment of contractual obligations. We may also use the information to advise you of other products and services provided by us, to confirm, update and enhance records, and to establish your identity. The data collected may be shared/transferred/stored/processed within or outside the Kenyan jurisdiction. Any reference to "We" or "Us" will mean Apollo Group. Refer to our website **www.apainsurance.org** to see the entities under Apollo Group.

I authorise APA Insurance to obtain and use my personal information as per the above. Yes ☐ No ☐

Note: In case you would like to revoke the consent, kindly send an email to **privacy@apollo.co.ke.**

I _____do hereby authorise any doctor, hospital, clinic or medical provider, any other company, institution or person who has record or information about me and/or my family members to provide my insurer with complete information including copies of their records with reference to my sickness or accident any treatment, examination, advice or hospitalisation. I have also been advised of and have understood the various exclusions. Any photocopy of this authorisation shall be taken as the original copy.

Patient/Parent/Guardian's Name: _____ Phone No: _____

Patient/Parent/Guardian's Signature: _____ Date: D D M M Y Y Y Y